Mt. Ascutney Hospital & Health Center

Budget Presentation

Green Mountain Care Board
August 23, 2021

Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

Presenting

- Joseph Perras, M.D., CEO/CMO
- David Sanville, Chief Financial Officer
- Theresa Tabor, Controller

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Agenda

1. Overview
2. Requests
3. Financial Information
4. Risk/Opportunities
5. Value Based Participation
6. Capital Budget
7. COVID-19

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1.0 Overview

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1.1 Our Mission

To improve the lives of those we serve.

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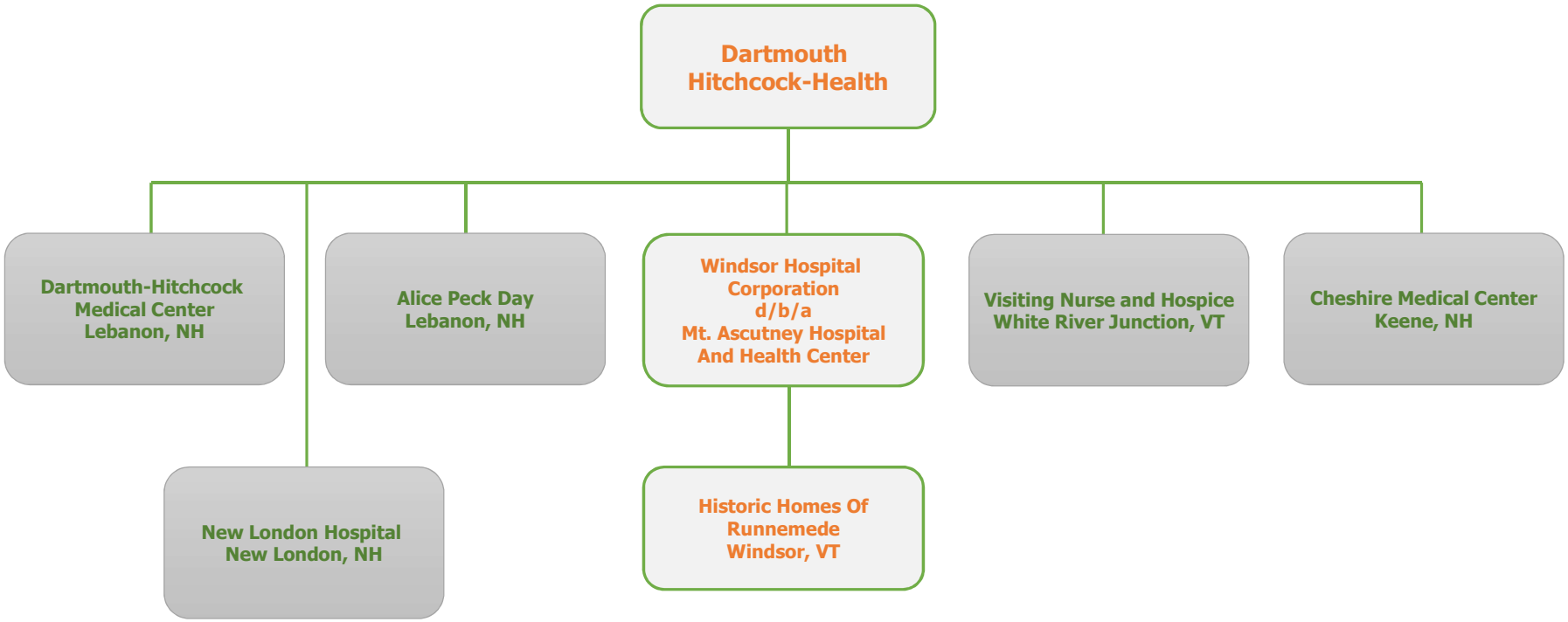
1.2 Organizational Chart



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1.3 D-HH Integration Activities

- Finance
- Supply Chain
- Pharmacy
- Regional Laboratory Services, Pathologists & Radiologists
- Medical Staff Functions - System Credentials Committee
- Specialty Medical & Surgical service line coordination
- Regional Healthcare delivery planning
- System-Wide Strategic Planning
- Operations/Shared Services/Shared Staffing
- Information Technology

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1.4 Current Service Lines

- Primary Care
- General Surgery
- Podiatry
- Ophthalmology
- Psychiatry
- Hospital Medicine
- Community Health Teams
- Cardiology
- Pathology
- Pediatrics
- Physical Medicine and Rehab
- Pain Management
- Radiology
- Rheumatology
- Gastroenterology
- Telehealth in Emergency Medicine and Psychiatry
- Urology
- Neurology

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Red = D-HH Provider

1.5 Recent Quality Scores

Patients who reported that their nurses "Always" communicated well.	87% National average: 81% Vermont average: 84%	Patients who reported that the area around their room was "Always" quiet at night.	53% National average: 62% Vermont average: 53%
Patients who reported that their doctors "Always" communicated well.	91% National average: 82% Vermont average: 85%	Patients who reported that YES, they were given information about what to do during their recovery at home.	92% National average: 87% Vermont average: 91%
Patients who reported that they "Always" received help as soon as they wanted.	79% National average: 70% Vermont average: 73%	Patients who "Strongly Agree" they understood their care when they left the hospital.	64% National average: 54% Vermont average: 57%
Patients who reported that the staff "Always" explained about medicines before giving it to them.	77% National average: 66% Vermont average: 66%	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	87% National average: 73% Vermont average: 76%
Patients who reported that their room and bathroom were "Always" clean.	82% National average: 76% Vermont average: 76%	Patients who reported YES, they would definitely recommend the hospital.	89% National average: 72% Vermont average: 76%

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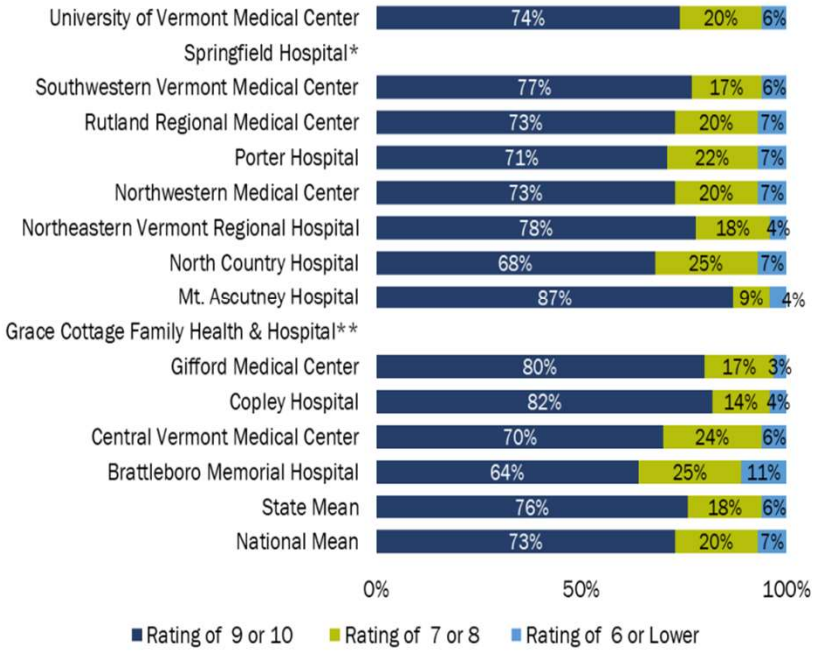
1.6 Recent Quality Scores

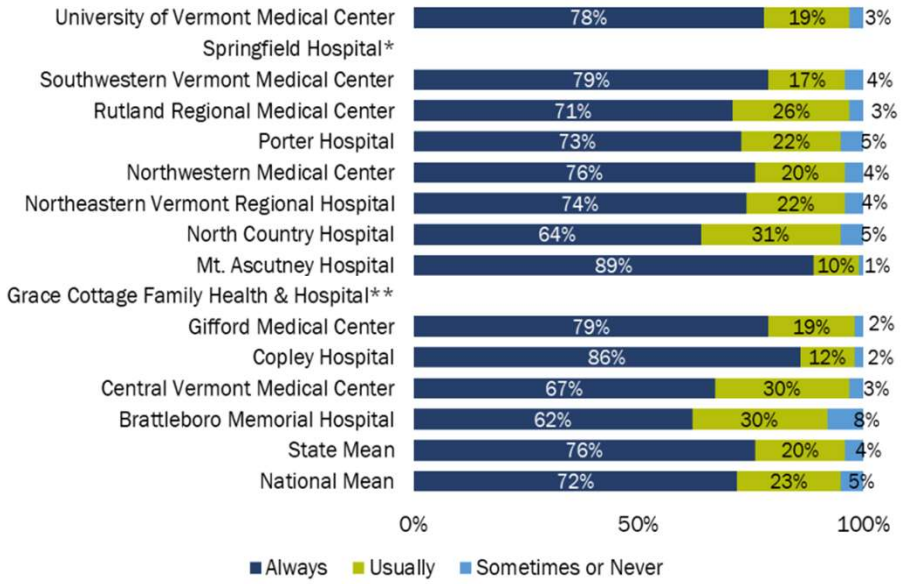
2021 HOSPITAL REPORT CARD

How Well Do Patients Rate the Hospital? (Scale of 0 to 10)***



2021 HOSPITAL REPORT CARD

Would Patients Recommend the Hospital to Friends and Family?



* Springfield Hospital's results are not available for this reporting period.
** Grace Cottage Family Health & Hospital's number of cases/patients are too small to report.

8/4/2021

VERMONT
DEPARTMENT OF HEALTH

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2.0 Requests

- Price Increase:
  - Rank 8 of 14 VT hospitals over last 8 years (1=highest)
  - Rank 6 of 8 VT CAH's over last 8 years
- NPSR/FPP Increase
  - Price Increase above plus volume

MAHHC

Request for NPSR and Rate Increase

	FY21 Budget	FY22 Budget	Change
NPSR	$ 56,211,391	$ 59,640,912	6.1%
Rate	4.6%	2.2%	-52.2%

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3.0 Profit and Loss

MT. ASCUTNEY HOSPITAL & HEALTH CTR PROFIT AND LOSS STATEMENT	
2022 BUDGET SUBMITTED	
GROSS PATIENT CARE REVENUE	$122,279,302
DEDUCTIONS FROM REVENUE	-$61,492,992
NET PATIENT CARE REVENUE	$57,823,629
FIXED PROSPECTIVE PAYMENTS & RESERVES & OTHER	$1,817,283
TOTAL NPR & FPP & RESERVES & OTHER	**$59,640,912**
OTHER OPERATING REVENUE	$4,368,119
TOTAL OPERATING REVENUE	**$64,009,031**
TOTAL OPERATING EXPENSE	$62,951,120
NET OPERATING INCOME (LOSS)	**$1,057,911**
NON-OPERATING REVENUE	$1,224,549
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	**$2,282,460**
OPERATING MARGIN %	1.65%
TOTAL MARGIN %	3.57%

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3.1 Balance Sheet

MT. ASCUTNEY HOSPITAL & HEALTH CTR BALANCE SHEET	
2022 BUDGET SUBMITTED	
TOTAL CURRENT ASSETS	$18,060,409
TOTAL BOARD DESIGNATED ASSETS	$30,311,222
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	$18,349,242
OTHER LONG-TERM ASSETS	$9,068,659
TOTAL ASSETS	$75,789,532
TOTAL CURRENT LIABILITIES	$17,567,209
TOTAL LONG-TERM DEBT	$22,457,136
OTHER NONCURRENT LIABILITIES	$729,107
TOTAL LIABILITIES	$40,753,452
FUND BALANCE	$35,036,080
TOTAL LIABILITIES AND FUND BALANCE	$75,789,532

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3.2 Cash Flow

MT. ASCUTNEY HOSPITAL & HEALTH CTR Cash Flow Statement	
2022 Budget Submitted	
Cash From Operations	
Excess Revenue Over Expense	2,282,460
Depreciation/Amortization	2,853,697
Patient A/R	(1,698,329)
Other Changes	226,208
Total	**$ 3,664,036**
Cash From Investing Activity	
Capital Spending	
Change in Accum Depr Less Depreciation	
Change in Capital Assets	(6,054,000)
Total	**(6,054,000)**
Increase/(Decrease)	
Other LT Assets & Escrowed Bonds & Other	
Total	-
Total	**$ (6,054,000)**
Financing Activity	
Debt	
Payments on Capital Lease	**$ (305,982)**
Total	$ (305,982)
Other Changes	
Change in Fund Balance Less Net Income	
Total	**$ -**
Beginning Cash	**$ 13,429,465**
Net Increase/(Decrease) in Cash	**$ (2,695,946)**
Ending Cash	**$ 10,733,519**

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3.a.1 NPR/FPP Assumptions

- Volume
  - Estimated with consideration of:
    - Budget FY19 & FY20
    - Actual FY19, pre-COVID FY20, Actual FY20, & YTD FY21
    - COVID-related limitations & recovery
    - Other known changes in operations, providers, etc.
  - Inpatient (versus FY21 annualized)
    - Acute days decreasing 2.5%
    - Swing days are increasing 30%
    - Inpatient Acute Rehabilitation days increasing 14.5%

3.a.2 NPR/FPP Assumptions

- Volume
  - Outpatient (versus FY21 annualized)
    - Emergency Room increasing 7% to normal levels
    - Infusion remaining flat
    - Laboratory decreasing 12%
    - Outpatient imaging decreasing 5%
    - Outpatient Operating Room up 6.5%
      - No anesthesia revenues
  - Outpatient Therapies (versus FY21 annualized)
    - Respiratory Therapy up 3%
    - Physical Therapy down 1%
    - Occupational Therapy decreasing 13%
    - Speech Therapy increasing 24%
    - Cardiac Rehabilitation flat

3.a.3 NPR/FPP Assumptions

- Volume
  - Clinics (versus FY21 annualized)
    - GIM increasing 2.5%
    - Pediatrics increasing 26%
    - OHC increasing 27% from
    - Psychiatry decreasing 10.5%
    - Rheumatology increasing 32%
    - Oncology down 50%
  - Clinics continued (versus FY21 annualized)
    - General Surgery increasing 3%
    - Pain Management decreasing 1%
    - Physiatry decreasing 7.5%
    - Podiatry decreasing 4%
    - Ophthalmology increasing 1.3%
    - Neurology is increasing 28%
    - Urology is decreasing 5%

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3.a.4 NPR/FPP Assumptions

- Payer
  - Commercial – No significant changes expected in reimbursement rates
  - Medicare – Predominantly cost-based reimbursement, so reimbursement should track with costs/inflation
    - Sequestration?
    - IRF/IPPS for Rehab Unit
  - Medicaid – Our assumptions are that Medicaid maintains the same overall reimbursement %
    - Since Medicaid does not typically cover inflation we have taken a bit of risk

3.b Change-in-Charge Request

Fiscal Year 2021 Budget Analy	Mt. Ascutney Hospital & Health Ctr				
CHANGE IN CHARGE AND NET PATIENT REVENUE INCREASE					
Change in charge is the average change in price for services provided.					
	FY2018	**FY2019**	**FY2020**	**FY2021**	**FY2022**
Approved % Change in Charge	4.9%	2.9%	3.2%	4.6%	n/a
Commercial Approved % Change in Charge					n/a
Submitted % Change in Charge	4.9%	2.9%	3.2%	4.6%	2.2%
Commercial Submitted % Change in Charge					

Hospital Inpatient Change in Gross Charges	2.5%
Hospital Outpatient Change in Gross Charges	2.5%
Professional Services Change in Gross Charges	2.5%
Primary Care Change in Gross Charges	2.5%
Specialty Care Change in Gross Charges	2.5%
Skilled Nursing Facility Change in Gross Charges	2.5%
Drugs	0.0%
Other (please specify)	

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3.c Adjustments

- iii. Adjustments (provider transfers and/or accounting adjustments)
  - No provider transfers
  - No changes in reporting/accounting
  - Material price changes in ancillary services

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3.d Other Operating and Non-Operating Revenue

- 340B = same as FY21
- Blueprint Funding – Flat (with uncertainty)
- Rentals, cafeteria, company store, etc. = FY21 + inflation
- Grants, change according to contracted revenues/contracted commitments
  - $150,000 subsidy (down slightly from last year)
  - No signed agreement, not considered
- Renting Staff up $80k
- Investment Income:
  - 5% return (realized and unrealized) BDF
  - 5% return (realized and unrealized) Restricted
- Fundraising: $250k

3.e.1 Expenses

Salaries/Wages/Benefits:

- 2-3% increase entered for all employees (effective 10/1/2021)
  - Additional markets as affordable next year
- Small increase for health benefits better than industry trend
- 3% "ER" contribution for 403b
- No Pension costs – TERMINATED!
- FTE's up…
  - Budget 2021 to 2022 = 3.3%
  - COVID-related

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3.e.2 Expenses

Non-Salary/Benefit Expenses:

- Supplies @ +1 to 3% inflation adjusted by volume
- Purchased Labor up 9.2%
- Purchased Services are increasing 9.1%
    - Shared Services Assessment from DHH $328k (some offset)
- Utilities up 5.7%
- Interest decreasing slightly
- Depreciation increasing 1.8%
- Provider Tax = increase by net revenue increase

3.f Operating Margin and Total Margin

MAHHC

Margins

	FY21 Budget	FY21 Projection	FY22 Budget
Operating Margin	0.3%	5.3%	1.7%
Total Margin	1.9%	10.9%	3.6%

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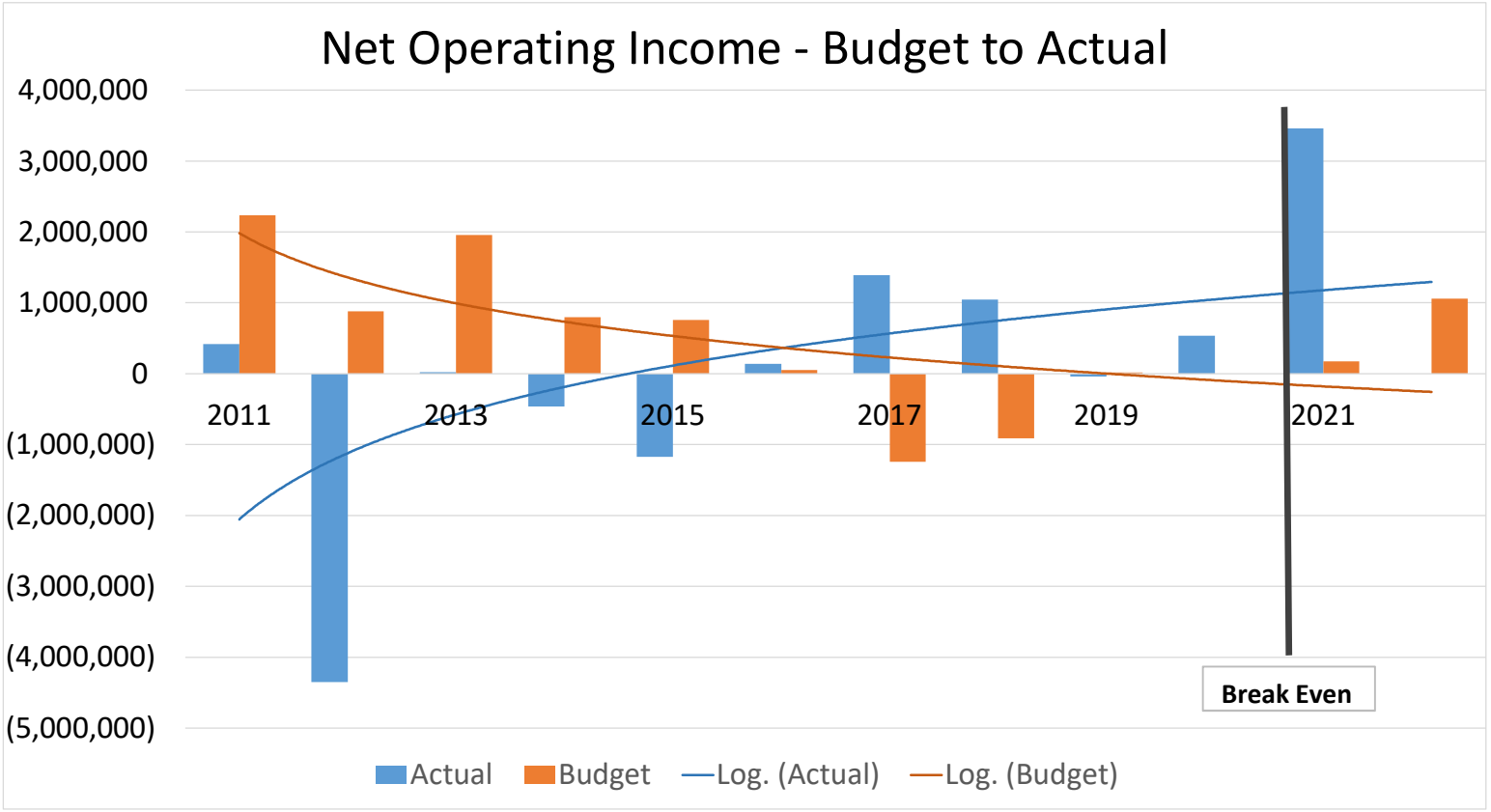
3.g.1 Other Financial Information - History



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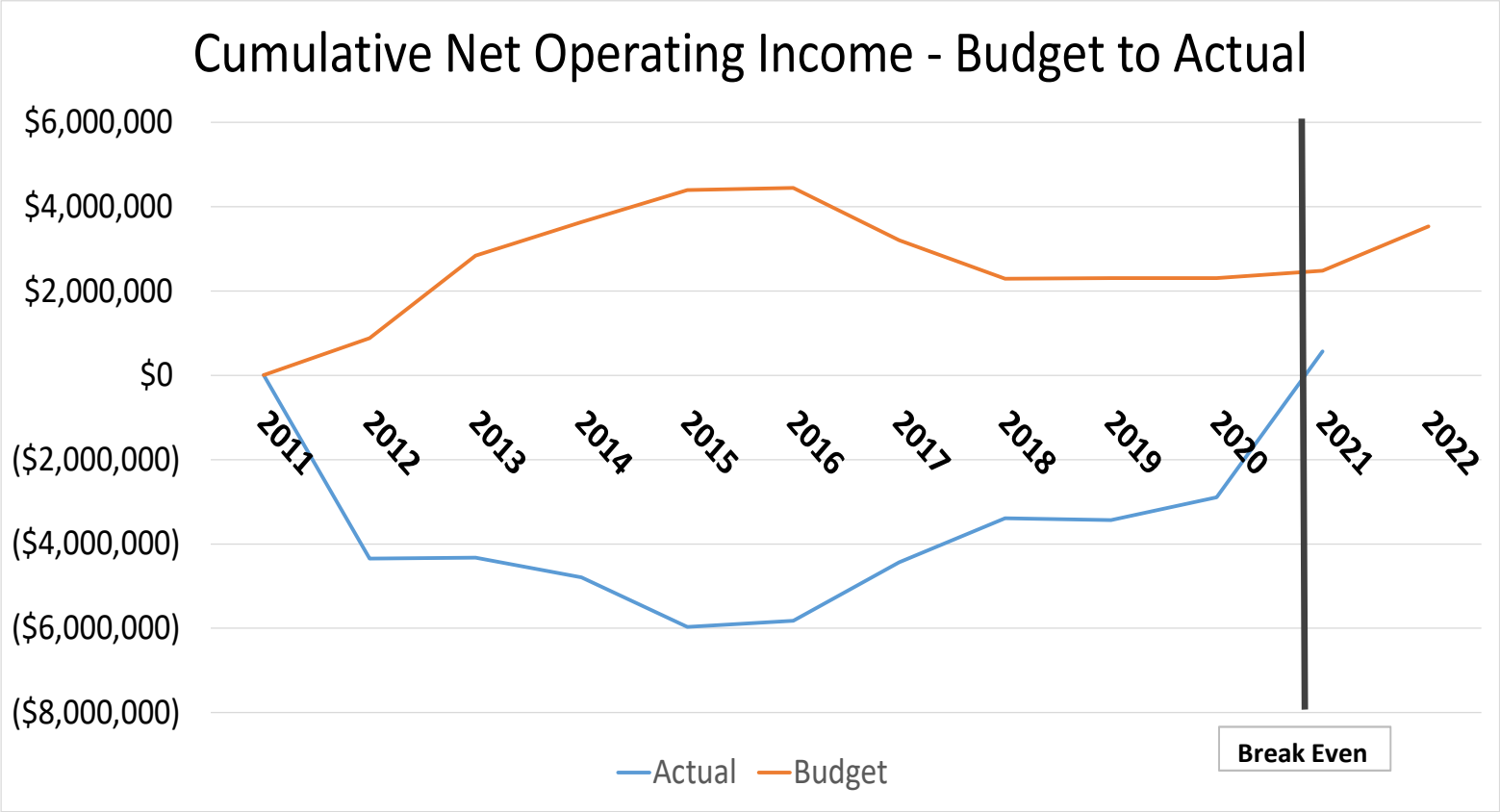
3.g.2 Other Financial Information - History



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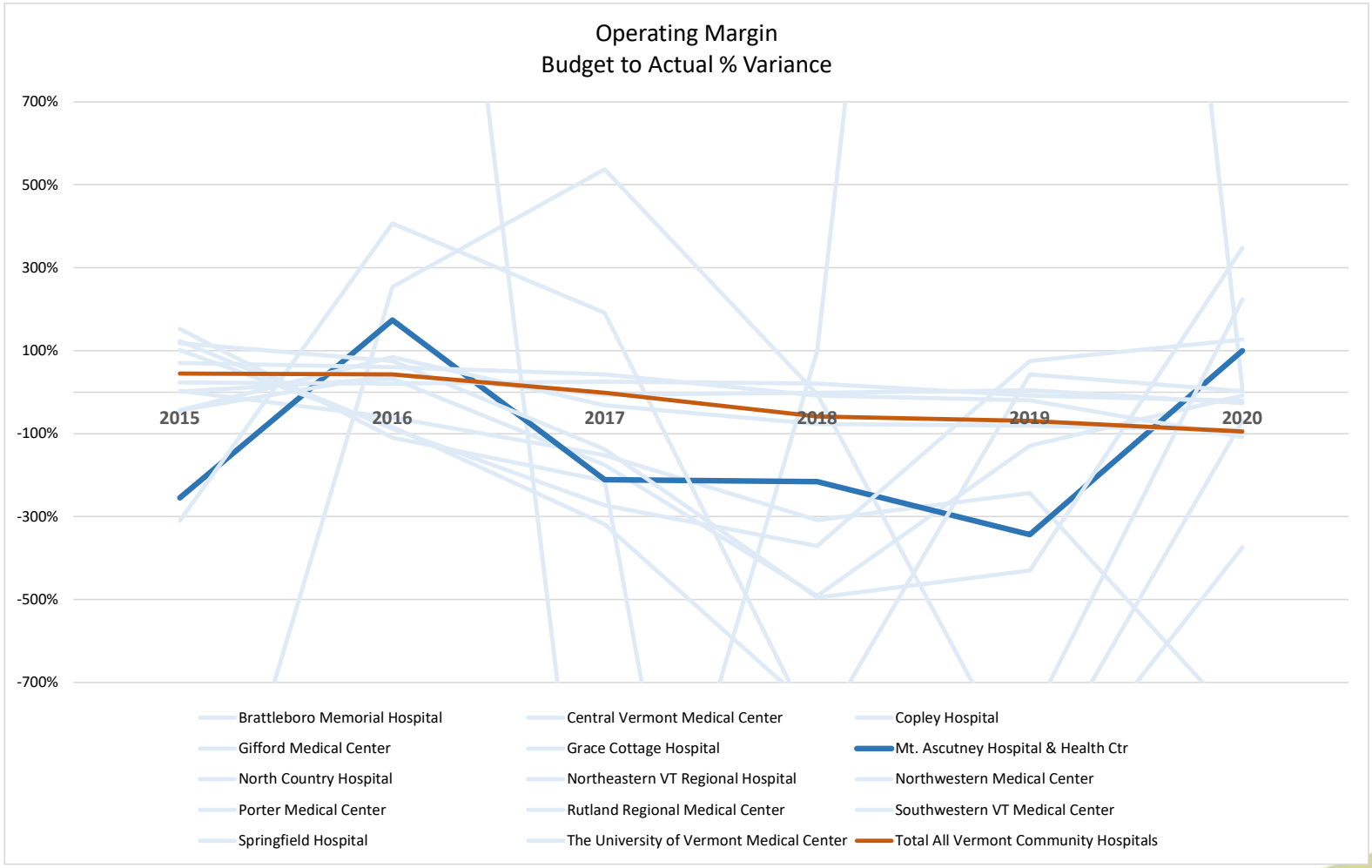
3.g.3 Other Financial Information - History



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4.0 Risks

- COVID-19
  - Delta and other variants
  - How do we sustain testing, evaluation and vaccination efforts (boosters, younger age groups) in a time of acute and chronic labor shortages?
    - Proving impossible for MAHHC over the summer, without reducing access to primary care services for our patients

- Healthcare workforce
  - Significant regional pressures as DHMC competes with Boston for talent. Driving wage and benefit expense up locally
  - New patient tower in Lebanon which will require hundreds of nurses and other staff to operate

4.1 Risks

- ACO engagement
  - We will remain in Core programs for 2022 (Medicare, Medicaid, BCBS) as approved by our Board of Trustees
    - There is no organizational enthusiasm to increase engagement
  - Downside risk could be a concern when/if National Emergency is declared over
  - Specialty (expensive) care occurring elsewhere
    - Largest spend in orthopedics, psychiatric care, and all specialty care at DHMC. Most of our region's ortho' care occurs in NH
- Staffing recruitment and retention
  - Wage pressures continue
  - Housing
- Uncontrollable inflation

4.2 Risks

- D-HH system needs vs. MAH needs vs. ACO needs vs. State limits

- Subacute Patients
  - Cost is far greater than reimbursement
  - Highest referral recipient in D-HH for subacute inpatients
  - Increasing difficulty to discharge to other settings

- Increasing dependence on Other Operating Revenues
  - 340B
  - Healthcare Reform Program Revenue
  - Grant funding

4.3 Opportunities

- Regional Planning
  - We are continuing to work closely with Valley Regional Hospital in Claremont, NH and that work will accelerate in 2022
  - Rational distribution of scarce resources and necessary services is imperative if we are to continue serving our communities
- Increasing and Improving Services Lines
  - Working to stabilize Urology program
  - Likely to have some utilization of our operating rooms by DH surgeons as DHMC is at capacity
  - No other immediate plans to add to our current portfolio of clinical service lines

5.0 Value Based Care Participation

Value-Based Care Program	Participating in Program in Calendar Year (CY) 2022? (Yes/No)	Budgeted Number of Attributed Lives (monthly average for CY 2022)	Budgeted Amount of FPP (monthly average for CY 2022)	Budgeted Maximum Upside/Downside Risk for CY 2022
Medicaid	Y	1,492	$ 139,357	$ 30,000
Medicare	Y	1,793	$ -	$ 270,000
Commercial (not Self-Insured)	Y	0	$ -	$ -

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5.1 Value Based Care Participation

iii. Has the hospital, and if so, how has the hospital, changed the way the hospital delivers care as a result of participating in value-based payment programs? Which value-based funding sources were most instrumental in driving that change?

iv. What barriers and opportunities are there to further delivery system reform in your community?

5.1 Response…

- The health care system in VT continues to face headwinds in its move toward value based care and reimbursement due to the state's unwillingness to match transformation funding from CMS at the time of ACO founding

- Hospitals have had to fund this transformation while putting themselves at significant downside risk

- It has been our experience that Next-Gen ACOs are not ideal vehicles for delivery system changes in critical access hospitals

5.1 Response (continued)

- The Blueprint for health laid the foundation for complex care management in the outpatient setting through its community health teams

- The PHM funding through the ACO has allowed our clinics to bolster nursing support for care management

- The data received from OCV enables us to identify areas of need for individual patients and for populations (ie Diabetics).

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5.2 Value Based Care Participation

v. What factors support, or inhibit, hospital participation in more value-based payment programs?

a. What is the "tipping point" or threshold, defined as the percentage that true FPP comprises of total NPR/FPP, necessary to support the successful transformation of your delivery system to a system substantially based on value-based care?

Response:

- Difficult to establish a threshold at this point
- Reminder 1/3 of our business is NH-based business and therefore FFS
- Migration of business from other HSA's
- Continued difficulties with shifting attribution numbers are challenging
- Trend skewed by COVID, payment issues, etc.
- Preventative and community health support commitment
- State commitment to draw down available Federal funds

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5.3 Value Based Care Participation

v. What factors support, or inhibit, hospital participation in more value-based payment programs?

b. Assuming Medicare and Vermont commercial payers offered a true actuarially sound population based fixed payment tomorrow, over what time horizon would you estimate you could reach your local tipping point? How long would it take your hospital to move operationally to a mostly fixed budget through participation in all-payer fixed payment programs)?

Response:

- We have developed systems and abilities to manage
  - Would need additional staff
  - Would need more timely and accurate data
  - Would need greater confidence in reporting and patient tracking
- More work load than any other payer relationship
- More expense vs. same access/quality/outcomes

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5.4 Value Based Care Participation

v. What factors support, or inhibit, hospital participation in more value-based payment programs?

c. What would the Medicare and Commercial fixed payment programs need to look like to facilitate your participation?

Response:

- Commercial would be the concern
  - Cost Shift
  - Ensure margin year to year, for multiple years in advance
  - Cover Inflation
- Medicare
  - Protect cost-based reimbursement for CAH
  - Consider effect of growing Medicare Advantage programs

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6.0 Capital Budget 2022

- 2022 Budgeted at $6,054,000
  - Catch up on last year
  - Normal year
- No CON's for 2022

Capital Budget - FY22	
Investment Type	**Amount**
Building and Building Improvement	$ 1,095,000
Land and Land Improvement	$ 120,000
Major Moveable	$ 4,838,900
Total	$ 6,053,900

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6.1 Capital Budget 2021

- Historically underfunded capital
- Predominantly Routine Replacement
- Nothing strategic beyond preparing for D-HH IT Implementation
- Bandwidth Issues

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7.0 COVID-19 Impact

Impact of COVID-19 on access to care/wait times at your organization, including the use of telehealth and telemedicine, COVID-19 related safety protocols, and other relevant factors.

7.0.1 COVID-19 Impact

Access to Care Wait Times: Non-Urgent/Emergent

Service Type	3rd Next Available Appt. (in Days)
Cardiology	96
Digestive Services	9
General Surgery	23
Hematology and Oncology	27
Internal Medicine	28
Neurology	41
Ophthalmology	31
Pediatrics	30
Physiatry/Rehabilitation	96
Podiatry	63
Primary Care	28
Psychiatry/Mental Health	15
Rheumatology	285
Urology	39

7.0.2 COVID-19 Impact Response

- We rapidly increased access to telehealth options for our entire patient population with an excellent EMR based solution.
- Half of primary care visits were telehealth based early on but quickly fell to 5-10%, why?
  - Payer mix
  - Broadband access
  - Other demographics
  - Provider dissatisfaction
- Psychiatry has continued robust telehealth support for their patients and we have added 2 psychiatrists during the pandemic

7.0.3 COVID-19 Impact Response (continued)

- Due to the shutdown of elective procedures during the pandemic and the retirement of a Gastroenterologist, we have significant backlog for screening endoscopy

- We have otherwise adapted well to safety protocols and have maintained clinical volumes

- Our current access and capacity issues are almost exclusively due to staffing/labor shortages
  - Critical issue

7.1 COVID-19…

- Impact on:
  - Personnel
  - Community
  - Financials
    - Revenues
      - Volumes
      - Payers
    - Stimulus
    - Expenses
      - PPE
      - Other

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7.2 COVID-19

- Personnel
  - System decision to avoid layoffs or furloughs
  - Held recruitment/hiring freeze for certain positions
  - Re-assigned staffing
  - COVID has pushed some staff into retirement
  - Added ~12 FTE's (26 people) for screening, COVID clinic, & Vaccinating
- Community

  SUD as an example
  - Windsor County overdose death rate rose dramatically
  - People using in isolation
  - MAHHC ramped up Narcan distribution,
  - Recovery coach availability 24/7 in ED
  - Coordination and scripting for EMS and other first responders to OD scenes to allow for immediate transfer to our ED for MAT initiation

7.3 COVID-19

- Increased behavioral health needs beyond SUD
  - Loss of jobs
  - Financial stress
  - Isolation
  - Remote learning and loss of socialization for children

  - All have led to increased need for BH resources, psychiatric care

  - Marked by increased volume of patients with BH crisis waiting in our ED for hospital beds

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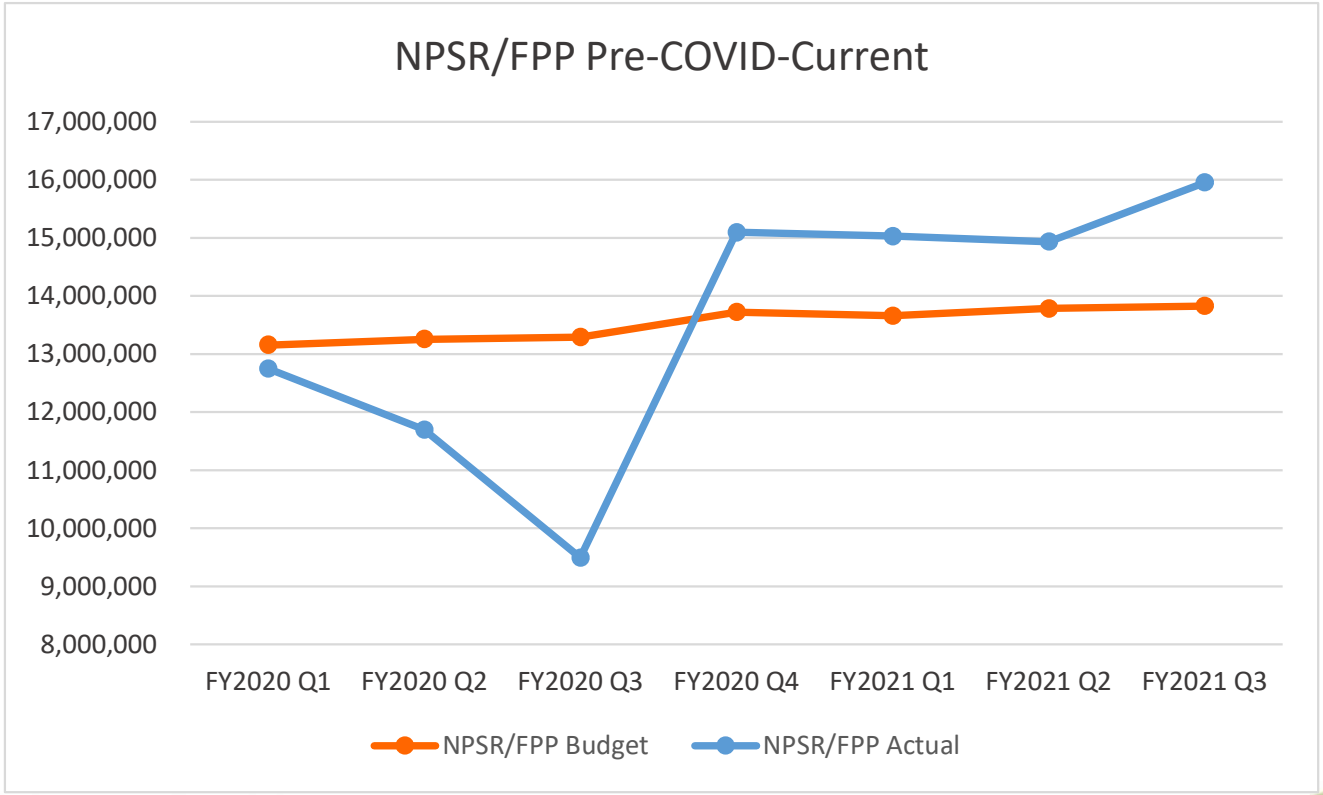
7.4 COVID19

- Impact on:
  - Financials - Revenues



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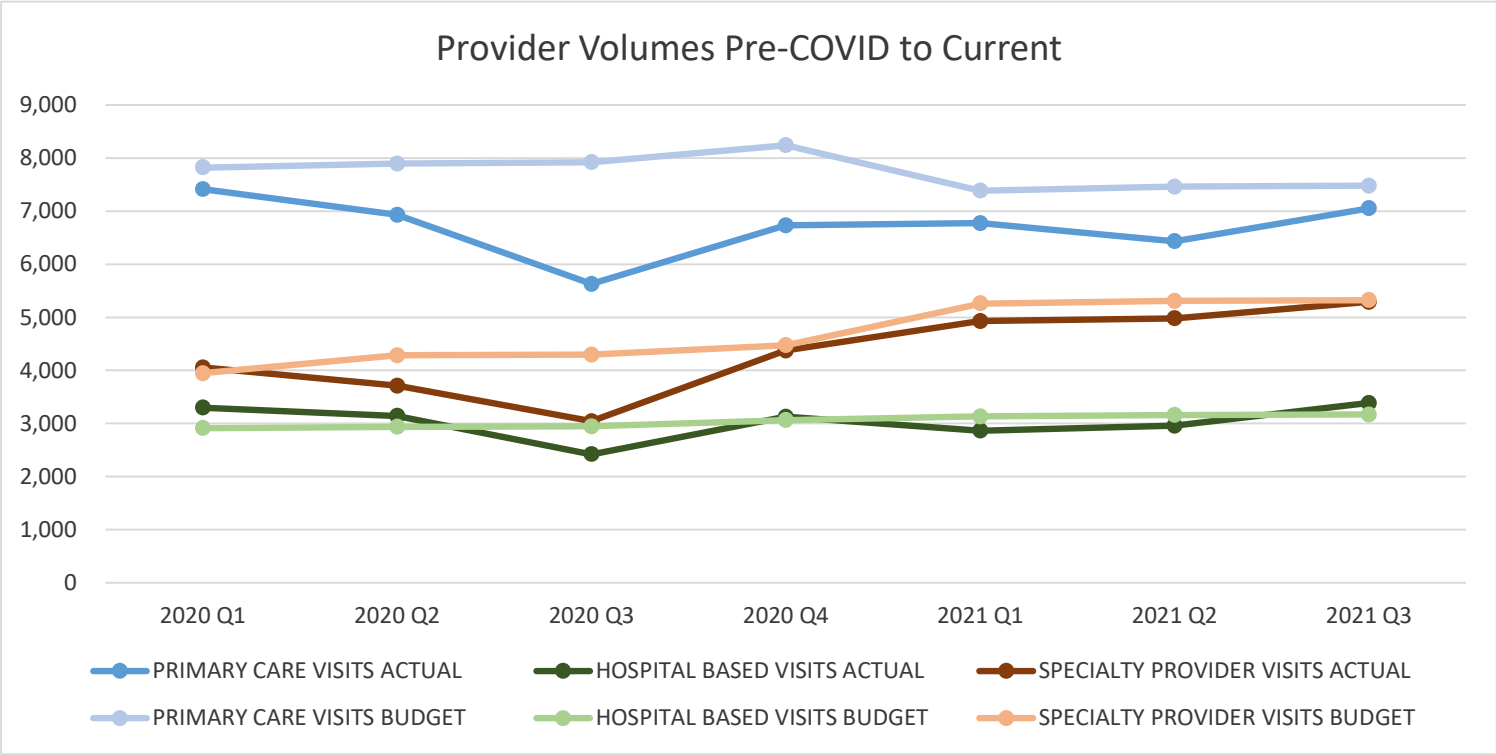
7.5 COVID-19

- Impact on:
  - Financials - Volumes



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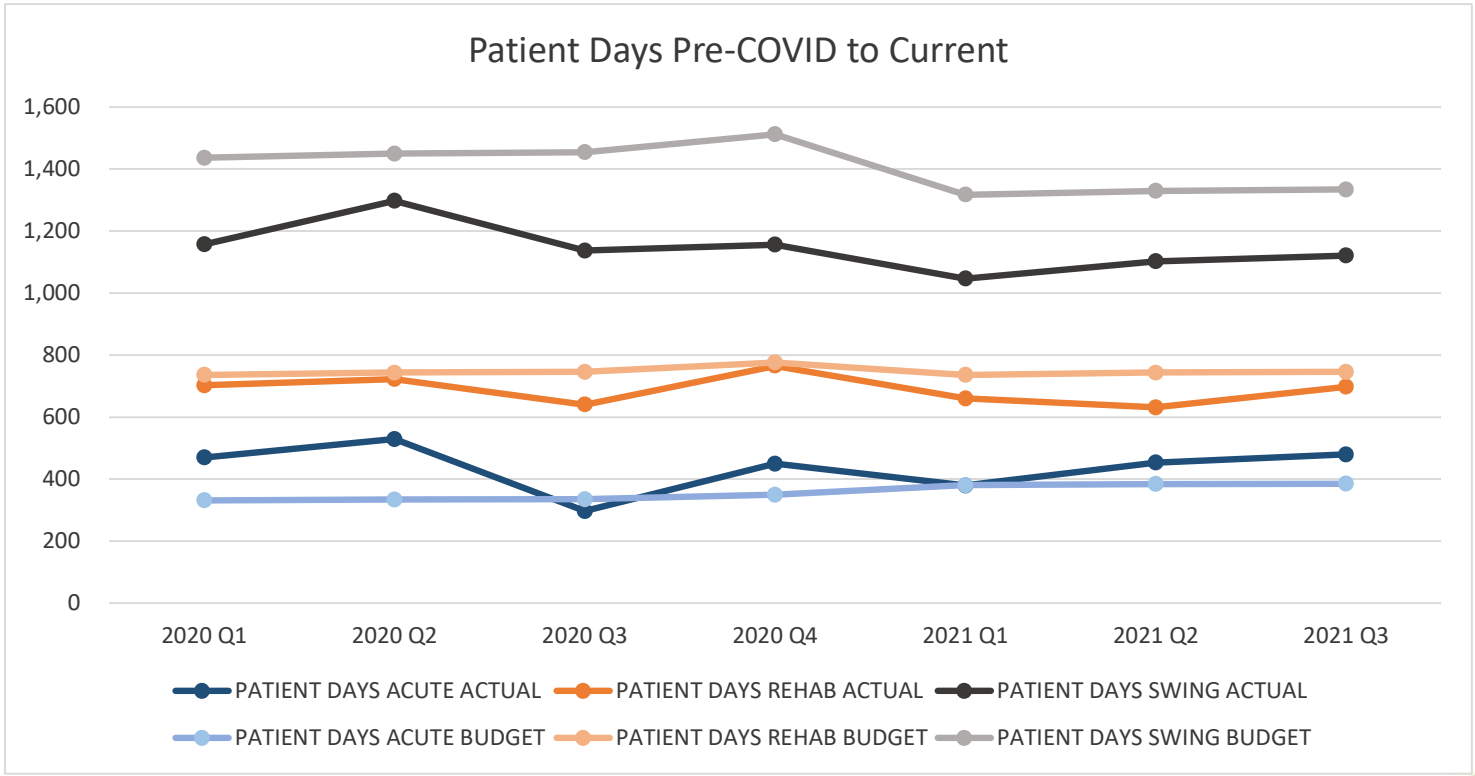
7.6 COVID-19

- Impact on:
  - Financials – Volumes (con't)



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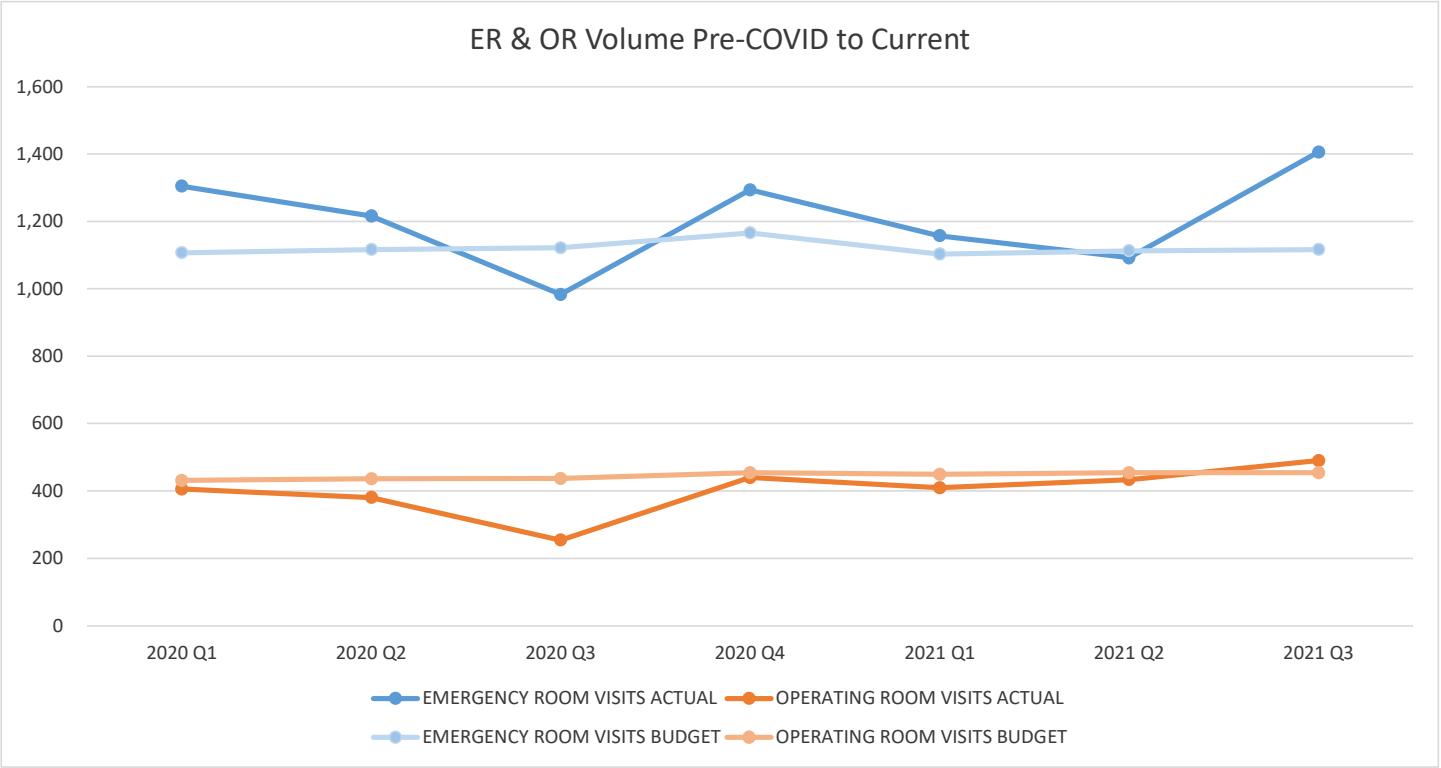
7.7 COVID-19

- Impact on:
  - Financials – Volumes (con't)



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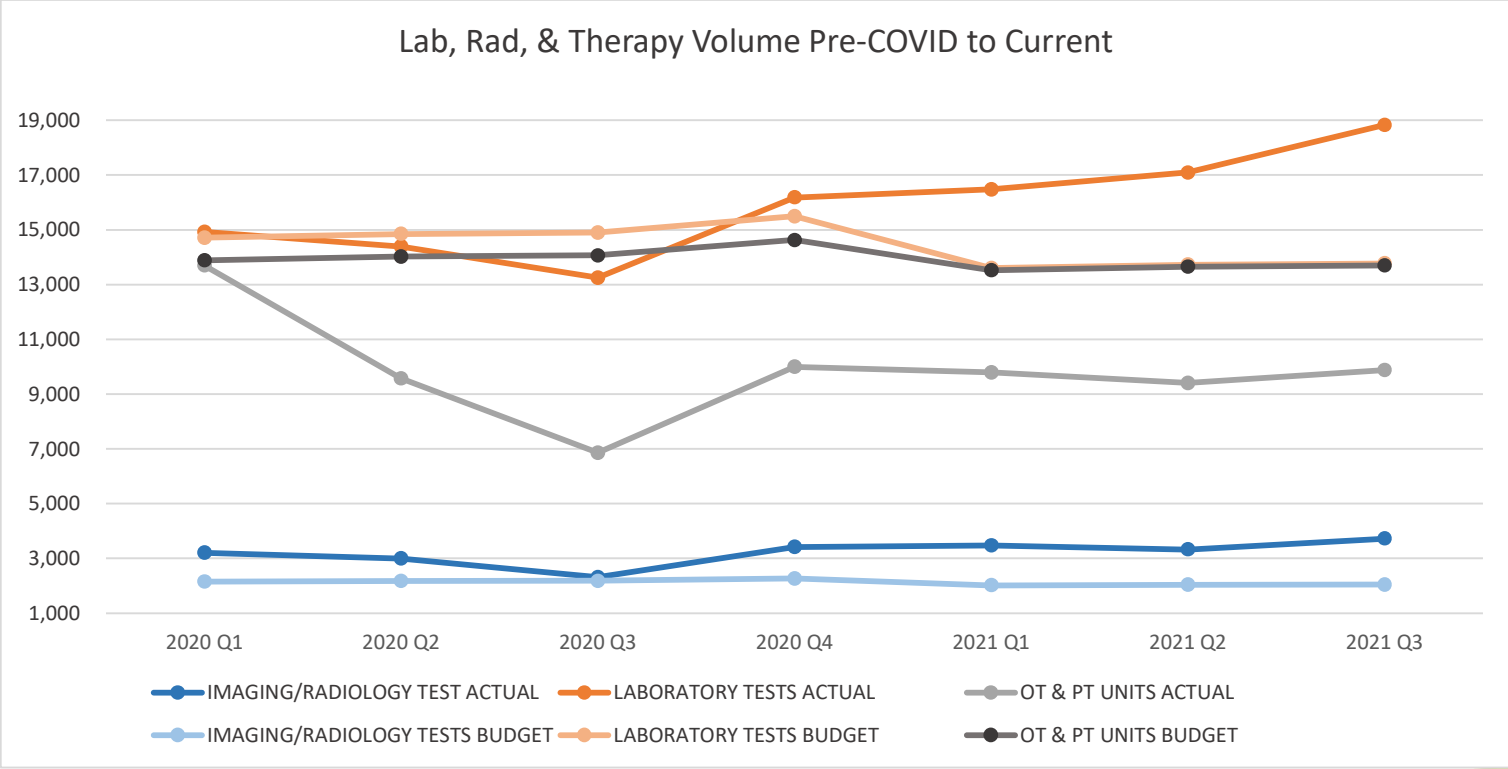
7.8 COVID-19

- Impact on:
  - Financials – Volumes (con't)



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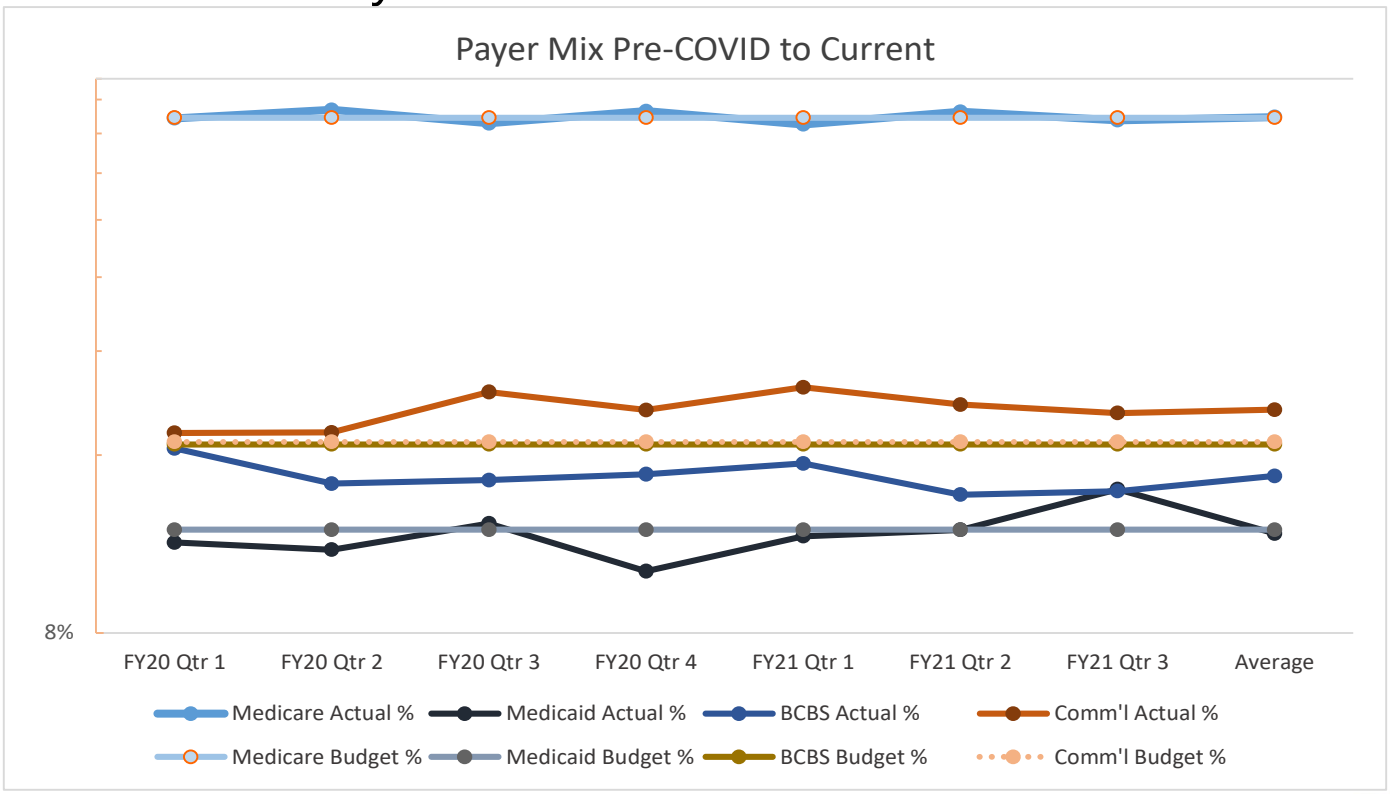
7.9 COVID-19

- Impact on:
  - Financials – Payer Mix



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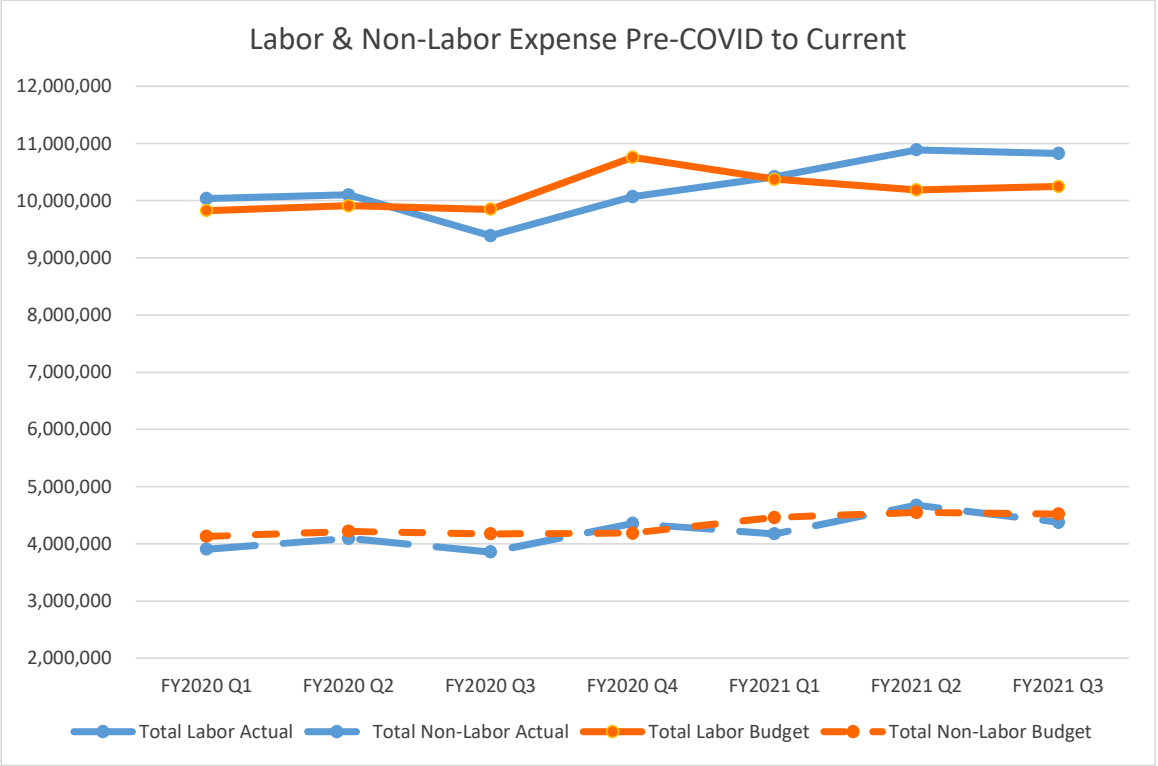
7.10 COVID-19

- Impact on:
  - Financials
    - Stimulus
      - ASPR Grant: $ 18k (offset by expense)
      - SHIP/FLEX Grants: $ 73k (offset by expense)
      - FEMA: $104k (offset by expense)
      - State COVID Vaccination $195k (offset by expense, YTD)
      - Hazard Pay: $202k (offset by expense)
      - Provider Relief Funds: $5.26m
        - Current Reserve: $2.66m
      - Medicare Advanced Funding $5.73m
        - Current Reserve: $5.73m

7.11 COVID-19

- Impact on:
  - Financials - Expenses



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8.0 HCA Follow Up Questions

How much funding in your current and future budgets has been allocated to diversity, equity, and inclusion (DEI) and/or racial equity focused projects, trainings, or collaborations?

8.0.1 HCA Follow Up Questions

- Current grant funding supported a community assessment and education program for BIPOC AND LGBTQ populations
  - Results will guide outreach efforts

- The Mt. Ascutney Prevention Partnership (MAPP) has funding in all 3 prevention grants – Tobacco, PEG, PCE/PNG – for DEI projects.
  - These activities are part of an overall budget, so it is difficult to quantify
  - Estimates that 20% of grants cover this work, ~ $100-120,000

- In the past year, MAPP has provided LGBTQ+ training to community partners and will offer it this grant year to Early Childhood providers.
  - MAPP sponsored an LGBTQ+ docu-series for community audience
  - MAPP/RISE VT sponsored Rise to 5K with health disparities messages placed on lawn signs along the route.

8.0.2 HCA Follow Up Questions

- MAPP drafted a needs and disparities statement compiling health disparities data and also updated the data for 2021
- Significant commitment of time assessing health disparity issues as they relate to risk of substance misuse
- Utilize state health disparities reports, YRBS data briefs, Windsor County Profile, etc. to understand how to direct resources and interventions toward underserved and high risk populations.
- Our Prevention Center of Excellence dashboard tracks disparities between the general MS and HS populations and LGBTQ students and students of color.
- Our PCE work looks to reduce those disparities for both risk and protective factors.

8.1 HCA Follow Up Questions

What percentage of staff and administrative leadership have received training in language access needs, implicit bias, and cultural competency?

8.1.1 HCA Follow Up Questions

- Every MAHHC employee undergoes annual compliance training around cultural competency

- We created a trauma informed educational series
  - Video and outreach to all our staff & community partners
  - Created a multidisciplinary and multi-agency task force to transform our hospital with using trauma informed care perspectives to build resilience
  - Set up a process to review all policies related to trauma informed care and DEI.

8.1.2 HCA Follow Up Questions

- DEI competency training for Rehabilitative Services department
  - Focused on LGBTQ
  - Revised screening tool
  - 60 individuals participated
  - PT, OT, Care Management, and nursing staff.

- Collecting data on the tool asking what did individuals learn from the competency.

- We have also welcomed international traveling nurses onto our units
  - Developed specific cultural competency education around their home regions.

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8.2 HCA Follow Up Questions

In what languages are your patient satisfaction the surveys available? Is race/ethnicity data collected as a part of these surveys?

- HCAHPS - Spanish, Chinese, Traditional Portuguese, Brazilian, Russian, Vietnamese
- OAS CAHPS - Spanish, Chinese, Traditional Russian
- Race and ethnicity is also an available data field in these surveys
- Race and ethnicity data is collected with our Healthy Workforce Initiative, CHNA, and D-HH System wide employee engagement survey (6/21)

8.3 HCA Follow Up Questions

For hospitals that have experienced a significant change in trends related to bad debt and free care before vs during the pandemic, we are interested in your perspectives about the causes of these changes. What happened on the ground? Were there any issues with patients' ability to learn about or apply for free care during the shut-down?

- Changes are not material
- Effect of pandemic was mixed
- Provided same or better access
- Provided more attention early in pandemic with lower volumes
- Seeing younger applicants

Thank you!

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